

TennCare
Prior Authorization

First Health Services Corporation
14955 Heathrow Forest Pkwy
Houston, TX 77032

Phone: 866-434-5524 **Fax:** 866-434-5523

Physician DEA Number:	Patient Information
Physician Name:	Recipient ID:
Physician Phone: <div style="display: flex; justify-content: space-between;"><div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div></div>	Recipient Name:
Physician Fax: <div style="display: flex; justify-content: space-between;"><div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div></div>	Recipient Date of Birth: <div style="display: flex; justify-content: space-around;"><div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div><div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div><div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></div></div>
Physician Signature:	

(By signature, the physician confirms the criteria information below is accurate and verifiable in patient records.)

Date of Request: _____

Drug Requested: _____

Quantity: _____ Length of Therapy on Prescription: _____

Dosage and frequency of dosing: _____

Diagnosis: _____

Previous therapy (include drug/dose/duration): _____

Reason for use of Non-Preferred drug or agent requiring prior approval: _____

Pertinent Lab data: _____

Other pertinent information: _____

Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

FOR **First Health Services** USE ONLY

Date: _____
Approved: _____
Denied: _____

Notified: _____
PA Number: _____
Reason: _____